Approved October 25, 2011

Minutes

Task Force on Employee Wellness and Consolidation of Agency Group Insurance

Tuesday, October 11, 2011

DHHS 401 Hungerford Road - Tan Conference Room

The meeting was called to order by Chair Bill Mooney at 8:05 a.m.

Approval of Minutes

The minutes from the October 4, 2011 meeting were approved without objection.

Request for Comments from Visitors

There were no visitor comments at this time.

Presentation from Paul Fronstin, Ph.D., Employee Benefit Research Institute, "What Do We Know About Consumer-Driven Health Plans"

A handout of the power point presentation was provided.

Dr. Fronstin provided the Task Force with background on the work of the Employee Benefit Research Institute noting that it is a private, non-profit, non-partisan organizations that does not take specific positions or lobby on issues but is funded by about 150 member organizations. The mission is to be an objective source of information.

Dr. Fronstin reviewed the differences between Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA). With the HRA, the employer controls the account and makes all the contributions ("anything goes"). It is generally used with a high-deductible plan. The HSA was created through an act of Congress in 2003. There are minimum contributions, statutory limits on deductibles, out-of-pocket expenses and maximum contributions. Once the contribution is made to the account, the account is the property of the employee. If you have an HRA you have an incentive to use it since it stays with the employer and the employer does not have to let you take the account with you if you leave the job. With the HSA there is an incentive to save since the employee owns the account and it is portable.

In 2011, 23% of firms offering health plans offer either a high-deductible health plan (HDHP) with a HRA or an HDHP with an HSA.

It was noted that there are tax advantage to having a HSA. The question was asked whether these plans might be threatened by federal budget cuts. Dr. Fronstin

said the opposite is likely because people think these plans will contain costs, so they will probably be encouraged.

Large firms are more like to offer these types of plans than smaller firms but when smaller firms offer them, they are likely to be the only plan offered whereas in large firms they tend to be one of several choices.

There does not tend to be an age difference for people in these types of plans but people in Consumer-Driven Health Plans (CDHPs) tend to have higher incomes, be less likely to smoke, less likely to be obese, and more likely to exercise. People with higher incomes may be more likely to take the risk of having a high deductible plan. Often the reduction in the HDHP premium (compared to traditional plan premium) will make up for the difference in the deductible and the savings from the lower premium can be recycled into the account.

In the first years of these plans, employers see that they can save money, especially if they do not contribute to the HSA. Dr. Fronstin noted the trend chart on slide 8 that shows that in the first 4 years, the percentage growth in the spending for CDHP versus traditional plans is much lower but that the trajectory for the CDHP shows it will eventually reach the same growth as the traditional plan. This is why some think it is more one-time savings that was achieved at the savings from the starting point.

Dr. Fronstin noted that even in an HDHP the same rule that 80% of your expenditures are due to 20% of your members applies. The people with chronic conditions drive the costs. There are about 14 chronic conditions that account for most of the spending on health care. They will exceed the deductible no matter how the plan is structured. Employers have shared with Dr. Fronstin that these plans do not do anything to reduce catastrophic claims.

Risk selection is also an issue and a reason why some employers are skeptical. There are few studies now that focus specifically on HSAs but it does appear that while there is no overall change to the risk pool, healthier people tend to select CDHPs. A 2008 study showed that there was a savings of 4.5% with CDHPs but that once you adjust for risk selection, the savings drop to 1.5%. Information from health care companies does not adjust for risk selection. Dr. Fronstin agreed with the comment that it may also have an adverse impact on the risk pool for other plans that are offered.

Dr. Fronstin discussed value-based benefit design. The HSA is the straight-jacket of value-based design because everything must be subject to the deductible. For example, some plans have eliminated co-payments for diabetes drugs to encourage people to take medications. This cannot be done with an HSA because it is not preventive care and therefore must be subject to the deductible.

Dr. Fronstin also discussed the need to educate people about how these health plans work. There are many questions people don't even know how to ask about how the HSA works. For example, the account belongs to the employee only (like an IRA).

In response to a survey, slide 14 shows that a higher percentage of those in CDHPs are offered health risk assessments and health promotion programs. Those with CDHP are more likely to participate in health risk assessment and health promotion programs that those in other plans. Information was provided on what people say would get them to participate in wellness programs including cash incentives and preferred plans.

Information on slide 19 shows the responses about whether people would chose doctors by their use of different types of Health Information Technology (HIT), those in HDHPs and CDHPs were more like to respond yes. In response to a question about whether Kaiser has studied the use of HIT, Dr. Fronstin said there are studies on Kaiser's use of HIT but that since they are a staff-model HMO they reap the benefits internally.

Dr. Fronstin provided information on the assets and rollover amounts in HRAs and HSAs. In response to a question about whether the insurance companies are making money off of these accounts, Dr. Fronstin responded that the insurance companies may have some fees, but that it is really the banks that benefit from these accounts because once the contribution is made it is a matter between the bank and the employee.

Dr. Fronstin was asked if there are studies about how to engage consumers in addressing chronic conditions. Dr. Fronstin said that there is nothing proven at this point but that some people are giving up on traditional disease management programs (such as telephone based programs) because they are not seeing results and the move has been to focus on value based contracting.

A question was asked about how these plans perform for people making lower incomes since they have less discretionary money to put into an HSA to offset high deductibles and out-of pocket expenses. Do they run the risk of increasing catastrophic claims for this population? Dr. Fronstin said that there is a valid concern for lower income populations. EBRI is currently undertaking a study and has been following a company with an HSA for 4 years to see what the trends are in cost-share and deductibles. He also noted that the tax advantage of these plans isn't as much for people with lower incomes.

There was discussion about the fact that CDHPs seem to focus on the patient knowing how to make the decision of what is needed but that value based plans seem to but this responsibility more on the health care provider.

Dr. Fronstin was asked if an employer could set up a CDHP that had a high deductible plan and an HRA or an HSA but them later take back or stop making contributions to the HRA or HSA? Dr. Fronstin said he had not heard of that, but what has happened is that employer contributions stay constant while the cost of premiums increases. He also noted that the large employers generally have the HRAs because the contribution can really be a paper transaction since the employer does not have to pay until there is a reimbursement claim.

The Task Force adjourned at 9:30 a.m. Task Force members were invited to stay for a presentation and discussion with Dr. Maria Prince of the Maryland Department of Health and Mental Hygiene that was scheduled for the Wellness Committee.

Attendees:
Task Force Members:

Sue DeGraba	Montgomery County Public Schools (MCPS)
Karen DeLong	AFSCME Local 2380
Denise Gill	FOP Lodge 35
Wes Girling	Montgomery County Government
Lee Goldberg	Public Member
Paul Heylman	Public Member
Tom Israel	MCEA
Rick Johnstone	MCPS
Jan Lahr-Prock	M-NCPPC
Mark Lutes	Public Member
Brian McTigue	Public Member
Edye Miller	MCAAP
William Mooney	Public Member
Richard Penn	AAUP
Farzaneh Riar	Public Member
David Rodich	SEIU Local 500
Carole Silberhorn	WSSC
Arthur Spengler	Public Member
Lynda von Bargen	Montgomery College
Michael Young	FOP Lodge 30

Alternates:

Karen Bass (for Lynda von Bargen)	Montgomery College
Debra Christner (for Ulder Tillman)	County Government
Amy Millar (for Gino Renne)	MCGEO Local 1994
Paul Brown (for Jan Lahr-Prock)	M-NCPPC

Guests:
Stan Damas, MCPS, Department of Association Relations
Councilmember George Leventhal
Lori O'Brien, Office of Management and Budget (County Government)
Patty Vitale, Chief of Staff to Councilmember Leventhal

Staff:
Craig Howard, Office of Legislative Oversight
Kristen Latham, Office of Legislative Oversight
Linda McMillan, Council Staff
Karen Orlansky, Office of Legislative Oversight
Aron Trombka, Office of Legislative Oversight